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ABSTRACT

This manual provides information and guidance for people (mental health professionals, other health professionals, paraprofessionals, school personnel, nonprofessional community volunteers, and youth workers) concerned with the mental health needs of adolescents who experience sexual assault. The four chapters provide these people with assistance in: (1) understanding the nature of sexual assault among adolescents--its incidence, causes and consequences; (2) identifying adolescent victims of rape and sexual assault; (3) providing needed support for adolescent victims, with particular stress on the range of community referrals possible; and (4) prevention strategies for avoiding sexual assault among adolescents. Chapter 1, Extent of Sexual Assault among Adolescents, defines sexual victimization and the relationship between victims and offenders and examines incidence according to the typology of the perpetrator. Chapter 2, the Reaction of Adolescents to Sexual Assault, describes developmental tasks of adolescence in relation to the trauma of sexual assault, classifies response patterns to sexual assault, and explains family responses to adolescent victimization. Chapter 3, Meeting the Needs of Victims and Offenders, offers disclosure patterns in sexual assault and ways to identify suspected cases, examines victim needs and offender needs, and suggests community referral. Chapter 4, Prevention Strategies, suggests strategies for the community, the family, and the individual. A list of 68 references is included. (ABB)

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the sexual victimization of adolescents

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Public Health Service
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the sexual victimization of adolescents

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Foreword

It is difficult to elicit information on incidence in as sensitive an area as sexual assault. Persons find it hard to talk about such trauma, and they are concerned about the effects of such disclosure on those close to them. But the studies that have been done point clearly to the fact that adolescents are particularly vulnerable to all kinds of sexual assault: stranger rape, acquaintance rape, and incest.

Studies concerned with adolescent development point out the number of critical changes taking place in the lives of adolescents. They are leaving a dependent social status as "child," "minor," "student," for that of adult, spouse, and worker. They are experiencing biological maturation that enables them to become parents. The challenges in their lives are urgent and real.

This monograph deals with the complex social problems surrounding nonconsensual sex among youth. It deals both with intervention and prevention measures on individual, family, and community levels. It is designed to provide important information to adults whom adolescents look to for advice, help, and friendship out of the home: school personnel, recreational directors, and health and mental health workers. These adults are in unique positions to guide and counsel, to assist young persons in the pursuit of prosocial, healthy relationships.

This volume is the first in a series of monographs for the helping professions produced by the National Center for the Prevention and Control of Rape. Its purpose is to more fully address the Center's mandate to educate the public on this major health problem, so that people may join forces to combat it immediately and effectively.

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Introduction

Rape and sexual assault continue to increase in communities across the nation. Adolescents, defined for this monograph as between the ages of 12 and 17, are particularly vulnerable and require special attention and programs.

This manual provides information and guidance for people concerned with the mental health needs of adolescents who experience sexual assault. The background, training, and experience of such people is expected to vary and may include:

- Mental health professionals who specialize in working with adolescents
- Other health professionals, such as nurses, physicians, social workers, and other specialists who work with youth
- Paraprofessionals, such as crisis workers and counselors
- School personnel, including teachers, counselors, and administrators, and members of the clergy who provide guidance to adolescents
- Nonprofessional volunteers from the community who have little or no training but who have personal experience with their own and neighbor's children
- Youth workers, especially athletic directors, coaches, and physical education teachers as well as workers in YWCAs or youth homes

The purpose of this manual is to provide these people with assistance in:

- Understanding the nature of sexual assault among adolescents--its incidence, causes, and consequences
- Identifying adolescent victims of rape and sexual assault
- Providing needed support for adolescent victims, with particular stress on the range of community referrals possible
- Prevention strategies for avoiding sexual assault among adolescents

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Chapter 1

Extent of Sexual Assault Among Adolescents

Typology of Sexual Assault

A review of journal articles and books, media presentations, and crime surveys over the past decade dramatically highlights the public's consciousness of sexual violence in our society. Due in part to the concerted efforts of the women's movement and the infusion of Federal monies for research and treatment in rape and sexual assault, the adult victim is now less likely to be viewed as provocative or "asking for it," and rape is understood as a violent and aggressive act inducing a crisis situation. Recently, attention has been focused on the sexual exploitation of children by adults known to the child who trade on their authority over the younger person to pressure for sexual activity. Slowly the myth of the seductive or fantasizing child is eroding, and children are being believed when they report victimization.

One population still remains neglected: young people who have graduated from childhood yet remain uninitiated into the rites and responsibilities of adulthood. The adolescent is a relative newcomer to the research arena. Lerner (1981), in keynoting the Conference on Research Directions for Understanding Stress Reactions in Adolescence, observed that a decade ago courses in adolescent psychology and adolescent development were not available in his graduate program and that adolescence was viewed as a relatively unimportant period. Thus, the dearth of research on the sexual victimization of the adolescent is not surprising. Given the limitations in knowledge, some strides have been made in the empirical and clinical literature on victims. The adolescent or pubescent teenager—the focus of this manual - has been noted to be at risk for sexual victimization by various predators including peers (Burgess and Holmstrom 1975; Ageton 1981); adult acquaintances (Finkelhor 1979; Geiser 1979; Schultz 1980); family members (Weinberg 1968; Giarretto 1976; Lystad 1982); and strangers (Uniform Crime Reports 1980; National Crime Survey 1981).

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Definitions of Sexual Victimization

Before describing the seriousness and extent of sexual victimization among adolescents, the reader should know something about rape and sexual assault.

Legal definitions of rape have expanded in recent years. Before the early 1970s, for instance, almost all jurisdictions defined rape as "illicit carnal knowledge of a woman, forcibly and against her will," with "carnal knowledge" customarily interpreted as vaginal penetration by the penis. This meant that rape laws failed to protect either males or separated spouses and overlooked all forced sex acts except vaginal intercourse.

Recognizing the limitations of existing definitions, anti-rape groups began to lobby for reforms that involved not only change in definition but much more protection of the rights of the victim. The Michigan Criminal Sexual Code was one of their first accomplishments. This law, still among the most comprehensive, includes four major revisions: (1) it restricts the use of a victim's sexual history as evidence for the defense; (2) it provides a degree of structure for assaultive sexual acts; (3) it eliminates resistance standards; and (4) it extends protection to males and separated spouses. By 1976, 36 other States had substantially revised their rape statutes, clearing the way for reforms within law enforcement and court sectors, and 13 others had proposed new laws.

In establishing the National Center for the Prevention and Control of Rape, the Federal Government itself adopted a broad definition of rape that included statutory and attempted rape as well as completed rape and any other criminal sexual assault, whether homosexual or heterosexual, that involves the use or the threat of force, including coercion and bribery of children.

Knowing the damage that may result from all forms of sexual victimization (e.g., anal and oral as well as vaginal penetration) clinicians have long supported such a comprehensive definition of rape. Now certain clinical researchers have expanded the concept of sexual assault still further by defining coercion to include more subtle forms of sexual pressure. Such situations involve persons of unequal power and status, with the person of higher status taking sexual advantage of the one with less power. These offenders are usually known to the young person, as in incest, prostitution, and pornography. These situations may be termed sexual exploitation, i.e., using a person primarily for another's gratification, profit, or selfish purpose.

Relationship Between Victim and Offender

Sexual assault, by definition, is an interactional process; that is, at least two persons are involved. In adolescent assault, three relationship patterns between victim and offender emerge from the research: stranger, nonstranger, and incest. Although all three

patterns may have serious and long-lasting effects, they are presumed to be different in a number of important ways: in the nature of the dominant behavioral, psychological, and cognitive reactions they provoke; in the issues they raise for service providers and other potential helpers; and in the techniques that may be helpful for treating existing cases and presenting new ones. The ensuing sections describe adolescent victimization in these categories.

Stranger. Survey samples do not usually separate adult and adolescent victimization incidence rates and there is no literature to suggest that information about rape incidence for adults differs significantly from that of adolescent reports. The prevailing belief that rape usually occurs between strangers and that victims are targeted at random is generally not true (Rabkin 1979). Studies vary markedly in reporting victim-offender relationship, ranging from 36 percent to 91 percent for stranger relationships. Amir (1971) found the offender to be a stranger in 42 percent of all rape cases (n=646) reported to Philadelphia police in 1958-60. Holmstrom and Burgess (1979) noted that 38 percent or 41 rape victims (5 of them younger than 17 years and 36 older) out of 109 victimizations reported to Boston police in 1972-73 were unable to identify their assailants. Rabkin believes victim underreporting to be a function of degree of acquaintance with the offender and suggests that stranger rapes probably account for 50 percent of all rapes reported to the police. Amir, using the term "ecologically bound," describes rape occurring predominately between residents of the same neighborhood, members of the same race, and at certain times of the day and week as key variables in relationship.

Nonstranger. Children and adolescents are particularly vulnerable to assault by a person known to them, i.e., nonstrangers. The known adult offender may be someone who lives near the adolescent or who has contact with the adolescent through recreational activities or sports, or by someone in an official association with the teenager, such as a teacher. The nonstranger may be another adolescent known through a social activity. Dating is the cultural ritual that allows young persons to test their developing sexuality and social skills in interpersonal and intimate relationships. How smoothly these encounters go depends on the attitudes and expectations about sexual behavior couples bring to the situation. However, it is important to acknowledge, as early theorists hypothesized, that most American children are socialized in a rape-supportive society and thus absorb gender-specific behaviors that legitimize rape. Dating within this context may become an arena for sexual victimization.

Recent studies of the causative factors of rape confirm the rape-supportive nature of sex-role learning, traditional dating patterns, and adherence to rape myths (Weiss and Borges 1973; Zellman et al. 1979; Burt 1980; Koss and Oros 1982). The research

reveals, for instance, that females associate femininity with softness, nonassertiveness, and dependence on men; are socialized to be alluring yet sexually unavailable; and are assigned the role of pacesetter in sexual situations. Males, on the other hand, are conditioned to be strong, powerful, and aggressive, highly valued measures of masculinity in our society. They are acculturated to be aggressors in sexual situations and to view a woman's resistance to sexual overtures as mere face-saving gestures.

How clearly these attitudes are adopted by adolescents and how strongly they influence their perceptions of male-female interactions was demonstrated by a study of 432 Los Angeles area adolescents conducted by Zellman et al. (1979). Despite the liberalization that has occurred in recent years, these adolescents (age 14 through 18) still had traditional views of sex roles. Further, male respondents viewed the world as "sexier" than females, i.e., they were more likely to assign sexual meaning to cues in social situations; males also were less likely to differentiate between love and sex. On the issue of force to achieve sexual intercourse, the findings were quite revealing. Some 82 percent of the males and the females initially indicated that force was generally never acceptable. Yet, when offered specific sets of circumstances involving force the proportion of those saying "never" decreased to 34 percent. Male and female respondents were very consistent in the belief that force is "all right" under certain conditions and is most acceptable when a girl leads a boy on or gets him sexually excited.

This common acceptance of forced intercourse serves only to perpetuate the aggressive tendencies of young males. Under these circumstances it is not surprising that adolescents concerned about their sexuality are vulnerable to date or acquaintance rape, especially if they adhere to common sexual scripts.

In studying adolescent victims and their offenders (Burgess and Holmstrom 1975) it became clear that not only are teenagers at risk for rape by peers but they may face multiple assailants. In the Burgess and Holmstrom study over half of the 17 adolescent rape victims were attacked by more than one assailant, a pair or a group of young males, and often the adolescent offender was from the same community as the victim. Several variations of teenage peer rape may operate: (1) multiple assailants and a single victim; (2) multiple assailants and multiple victims; (3) multiple assailants and multiple serial victims; and (4) peer rape in tandem (e.g., offenders who group together specifically to rape). In our culture, gang rape is supported by the myth: they are just young boys sowing their wild oats.

Incest. Incest, like rape, is a legal term and is proscribed in every State. Although statutes vary, incest usually refers to sexual intercourse between two persons so closely related that they are forbidden by law to marry. However, we can see the ambivalence

in our societal attitudes just over the controversy about whether or not to involve some incest offenders in the criminal justice system. As social scientists have observed, women and children have been considered property and that usually has meant that adult male family members could and perhaps still can do whatever they want to members of their own family.

Clinical definitions are helpful to consider when dealing with the problem of incest. Herman and Hirschman (1981) differentiated incest (any physical contact between parent and child that has to be kept secret) from seductive behaviors (peeping, exhibitionism, leaving pornographic materials within sight for the child, sharing detailed descriptions of the child's real or imagined sexual activities).

Incest is now known to occur much more frequently than previously imagined. In 1968, Weinberg reported annual incidence at an estimated 1.9 cases per million population in this country; by 1976, Giarretto estimated annual incidence at the much expanded rate of 200 cases per million. Experts suspect that even current estimates greatly understate the problem, which is not only underreported to legal authorities but also shrouded in intense secrecy.

The most commonly reported adult-child sexual activity occurs between daughter and male in caretaking role (e.g., father, stepfather, mother's paramour) and the least reported between mother and son. Although female victims outnumber males in reported cases, clinical studies reveal that boys are not exempt from the problem. According to Giarretto, 10 years is the average age of onset for an incestuous ongoing relationship involving an eldest daughter. Typically, the victim's participation is gained through the application of authority, subtle pressure, persuasion, or misrepresentation of moral standards (Burgess and Holmstrom 1975). Trust of parents and obedience appear to be key factors placing children at high risk of sexual abuse. This latter observation is important in the context of this manual, for as children approach puberty, even very trusting and obedient children may begin to question their parents' authority, and those who have been incest victims may begin to see their situation through new eyes, looking for ways out. Also, one of the most consistent findings in the incest literature reviewed by Herman (1985) was the unusually high rate of serious illness or disability in mothers of sexually abused daughters, which places the child's care much more in the hands of fathers.

Incidence of Sexual Assault Among Adolescents

It is difficult to obtain a true grasp of the scope of the problem of adolescent sexual victimization. Statistics on the incidence of adolescent victimization vary considerably for several reasons. First, there is no centralized National or State recording system or

index for sexual offenses against youths (Schultz 1980). Second, a true measure of this problem is almost impossible to obtain because children and adolescents typically are extremely reluctant to report sexual assault to parents or significant others (Landis 1956; Peters 1973). Third, agencies may report child and adolescent sexual assault figures with the adolescent range included in both, e.g., age 16 and under for child and ages 17–19 for adult. There is confusion over what ages to include in defining a minor, adolescent, or juvenile (Schultz 1980). The data on the age of victims depend to some extent on the definition of the crime and the age used for reporting statistics either via an agency or by researchers. Adolescents usually come to the attention of an official reporting agency through an adult (e.g., parent, teacher) who finds out about the rape or notices visible injuries. This lack of reliable incidence and freqency data, argues Schultz, makes it difficult to present the problem to the public to influence policymakers, law enforcement and budget bureaus, and human service agencies in providing resources.

The above concerns notwithstanding, several strata of incidence reporting may be examined to provide some preliminary understanding of the numbers of sexually victimized adolescents by the typology of the perpetrator.

Stranger Rape

The FBI national crime reporting statistics (1981) did not include males among the victims of reported forcible rape, but did provide summary statistics on females of all ages (n=82,090). In 1980, an estimated 34.4 out of every 100,000 females in the country were reported rape victims, a 94.2-percent increase over 1971. Since older adolescent girls are at particular risk for rape, it is safe to assume that the reported rape rate for adolescents is considerably higher than this. Also, these data consisted primarily of cases of stranger rape.

Nonstranger Assault

Another source of incidence data is the Natonal Crime Survey (NCS), a household survey to identify crimes that are not reported to official agencies and which, therefore, do not appear in the FBI national crime statistics. These data include acquaintance rape. The 1979 NCS provided the following profile on reported cases of sexual victimization:

> Victimization occurred at the rate of 2.5 cases per 1,000 females age 12 to 15. This rate climbed precipitously to 5.7 cases per 1,000 females age 15 to 19. The next age group, females 20 to 24, reported a somewhat lower rate of 4.7 per 1,000. Protection then came with age: females between 25 and

34 reported a rate of 2.1 per 1,000; those between 35 and 49 at a rate of 1.00 per 1,000; and those 50 and over at a statistically unreliable level of 0.1 per 1,000.

The sexual abuse of boys has been seriously neglected, in both understanding the incidence and providing services. Although statistically reliable estimates could not be developed for males using the NCS, the figures in the report create the same profile as for females: victimization starting at a rate of 0.2 per 1,000 males in the 12- to 15-year range, quickly reaching a zenith of 0.7 in the 16- to 19-year group, then dropping to 0.5 for males age 20 to 24, to 0.4 for ages 25 to 34, and to 0.1 for those between 35 and 64.

Incest

Another source of victimization data, the National Incidence Study (Burgdorf 1981), surveyed cases reported to various kinds of agencies: hospitals, child protective agencies, police, and courts. This study found 0.7 per 1,000 cases of sexual exploitation, defined as sexual assault or abuse of a child by a parent or other adult caretaker whose acts included genital penetration, genital or breast contact, or unspecified behaviors. Thus, the focus of this survey was on abuse committed by caretakers and parents (i.e., incest) rather than stranger or nonstranger.

A fourth population to study for incidence is young persons living in residential facilities. No statistics are available on the incidence of child maltreatment, especially sexual victimization, in these settings. Harrell and Orem (1980) reported that over 400,000 children were living in childcare institutions such as treatment centers, temporary and long-term shelters, detention homes, youth correctional facilities, centers for the mentally retarded and developmentally disabled, and group homes, with an additional 400,000 children in foster homes. The sexual victimization of juveniles in institutions other than correctional has been virtually neglected in the literature (Shore 1982). Sexually abused children residing in childcare homes are viewed by Shore as one of the most invisible and oppressed of all underserved populations--a population "at home" and behind closed doors. The literature is beginning to cite and suggest parallels and differences between maltreatment occurring within a residential institution charged with the care of the child and within a child's own family. As Harrell and Orem (1980) illustrate, institutionalized child abuse and neglect is a direct derivative of the nature of institutions, and, in most cases, at least tacitly supported by them.

Gender of the Victim

The studies comparing sexual abuse of girls and boys are diverse, and in clinical populations and general surveys, girl victims out-

number boy victims three to one. Finkelhor (1979) in his survey of 796 college-aged students demonstrated what has been reported throughout the clinical literature: children are at high risk for sexual assault and they do not report it. In his sample, 19.2 percent of the women students surveyed had had a sexual encounter with an adult (the mean age at the time of exposure was 10.2 years, and 63 percent of them did not tell anyone of the experience). In the sample, 8.6 percent of the male students had had a sexual encounter with an older person (mean age of 11.2) and 73 percent did not tell at the time.

Swift (1977) surveyed mental health professionals in an urban mental health center and found that males made up one-third of the child case load in treatment reporting sexual exploitation; one-fifth of the adult case load reporting sexual exploitation as children; and one-sixth of the victims of self-confessed exploiters seen in treatment. However, police and law enforcement agencies report seeing twice as many boy victims as are found in general surveys or clinical settings (Finkelhor 1979), and clinicians and law enforcers seeing child and adolescent victims of sex-ring crimes find males more frequently victimized than females (Burgess 1984).

In comparing incidence data for stranger, nonstranger, and incest, it is apparent that stranger rape is underreported, and nonstranger and incest sexual exploitation and abuse are even less often reported.

Fresh evidence to this effect is beginning to surface from a multiyear, national survey of adolescent vulnerability to sexual assault conducted by Suzanne Ageton. As defined in this survey, sexual assault encompasses a range of sexual pressuring, from familiar and somewhat expected verbal ploys to unbidden violence. Ageton's preliminary findings strongly support two clinical impressions: (1) that the vast majority of adolescent victims are assaulted by someone they know; and (2) that very few of these cases ever come to the attention of parents, police, or any other responsible adults.

- An overwhelming 92 percent of identified female victims of sexual assault (n=64) were acquainted with their assailant(s): 56 percent of these nonstranger victims had been attacked by a date, 30 percent by a friend, and 11 percent by a boyfriend.

- The majority (78 percent) of victims did not relate the incident to their parents, but most (71 percent) did tell one or more friends. A mere 6 percent of the victim sample contacted the police, the absence of injury and prior acquaintance with the assailant being the most common reasons for not reporting.

Finally, a minimal number sought professional assistance or advice. Above all, Ageton's research underlines the peer orienta-

tion common among adolescents and their typical reluctance to communicate openly with adults. It suggests that adults who work with youth are themselves unlikely to be approached by adolescent victims of nonstranger rape and that indirect methods will be required to deal with most individual incidents of this kind.

The incidence data, difficult as it is to obtain, reveals a minimum of 32.9 sexually victimized adolescents for every 100,000 adolescents in the general population. This estimate for primarily incest is extrapolated from the National Incidence Study (Burgdorf 1981). It stated that 38 percent of the general population in the United States fell between the ages of 12 and 17. However, their "in scope" population (i.e., maltreated children) was 47 percent for the 12-17 range, suggesting that young adolescents (21 percent in the age range 12-14 and 26 percent in the age range 15-17) are more likely to report a sexual victimization than younger persons, at least in incest situations.

There are strong indications that many more adolescents have been sexually victimized, the estimates ranging from a conservative double to even triple the numbers reported when including stranger and nonstranger sexual assaults. The rates are even higher in the population made more vulnerable by family disorganization, an absent or incapacitated parent, psychiatric illness or retardation, running away, and institutionalization or foster care. Thus, adults whose work brings them into contact with adolescents might expect about 20 percent of the general population to be sexual victims, about half of them having never disclosed this fact to a responsible adult. Adults working with high-risk vulnerable adolescent populations can expect to find even higher percentages of victimization in childhood and/or adolescence.

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Chapter 2

The Reaction of Adolescents to Sexual Assault

Developmental Tasks of Adolescence in Relation to the Trauma of Sexual Assault

Adolescence has long been recognized as a development period frought with stress. It is a time of extraordinary change, multiple conflicts, and marked societal demands upon the individual for the successful completion of significant developmental tasks (Garmezy 1981).

Hormonal, physiological, and somatic changes are reflected in pubertal development. Over an average span of only 4 years, the child is transformed, in terms of physical characteristics, into an adult (Peterson and Taylor 1980). Equally important psychological demands are induced by puberty: a heightened sexuality, the growth of peer attachments, a striving to achieve autonomy from and to reduce dependency upon parents, the assumption of specific gender roles, and a heightened search for personal identity (Garmezy 1981).

The search for identity is facilitated in adolescence by the cognitive changes that occur during this period. The acquisition of formal logic accounts for some but not all of the shifts that take place. Identity is an abstraction, as are concepts such as justice, friendship, loyalty, and morality. To comprehend these abstract concepts, a child can no longer be bound by concrete thinking. Foresight in problem solving and the ability to inhibit impulses and delay gratification are further accompaniments of cognitive growth and maturation (Keating 1981).

Conflict tends to be focused on parents as the most significant adults in the life of the adolescent. The roots of such stressful experiences are often to be found in the disparity between the values of the adolescent peer culture and the family. Although such parent-adolescent disagreements are commonplace, their frequency does not necessarily moderate their intensity (Garmezy 1981).

As for societal demands, one need only consider the many developmental tasks adolescents must successfully complete in their transition to adulthood:

- Achieve the gender-appropriate social role
- Accept one's body image
- Achieve independence from parents
- Find a responsible sexuality
- Complete requisite academic goals
- Prepare for an occupation
- Develop a set of values necessary for filling later roles as spouse and parent
- Evolve a set of values and a philosophy of life that will be compatible with successful evolution into adulthood (Garmezy 1981).

These many changes can be viewed as stressors in the sense that they require significant adaptation to restore a sense of inner harmony and homeostasis to the individual. The major transitions to roles related to sexuality and academic, occupational, interpersonal, and social responsibility bring discomfort and emotional distress in their wake. Thus, it is not surprising that any form of sexual victimization can easily disrupt the adolescent's development, producing serious effects in both the short and long term.

To appreciate the possible profundity of these effects, it is necessary to comprehend development as a cumulative process and to understand stress response patterns. Erik Erikson's (1950) Eight Stages of Development in the Human Life Cycle describes each life stage as involving certain developmental themes and tasks which also have negative alternatives; moreover, each stage is an integral part of the developmental process. Success in completing one set of developmental tasks prepares the individual for the next phase and also contributes greatly to the resolution of the crisis issues about to be encountered. As a corollary, disruption at any point can compromise the individual's ability to accomplish the tasks required at succeeding phases and can also imperil the accomplishments of earlier phases.

Sexual assault takes on specific meaning to victims according to

their stage in the life cycle. The helper needs to look at the developmental point of the victim and try to understand what the attack means to a victim at that age.

The major developmental task for adolescents is gaining a sense of identity. Their previous trust in their body is somewhat shaken by their rapid growth, and they must gradually reevaluate this new image. Thus, for the adolescent, whose primary task is self-definition, sexual assault tends to produce feelings and behaviors of a special kind. The assaulted adolescent female, for instance, may be worried about pregnancy in particular and may be acutely aware of her continuing vulnerability. The assaulted adolescent male may be conflicted about his gender identity and have fears of homosexuality when raped by another male. For both, the assault may constitute a frightening, ego-shattering experience, engendering feelings of extreme helplessness, particularly in forcible rape. The issue of sexuality may be more pronounced in incidents involving peers and/or acquaintances. In either case, how well the adolescent recovers from the assault will depend largely on his or her previous psychosocial functioning, the coping and personality style, the level of maturity, and the type of support received from those around. When adolescents conceal their feelings and experiences from others, they have the difficult task of using only their own inner resources to heal and integrate the incident adaptively.

A second important consideration in evaluating the impact of sexual assault on an adolescent is the stress response pattern of the victim. Clearly, the same phenotypic experience causes different reactions in different people and requires distinct coping mechanisms and internal processes (Moss 1981). In arguing for a taxonomy of stress, Moss suggests the following distinctions:

- Normal developmental stress: Individuals have to master the developmental challenges inherent in their stage of life; mastering and dealing with these challenges could constitute stress for the individual.
- Chronic stressful conditions: This classification includes serious illness, handicaps, extreme poverty, or feelings of second class citizenship because of minority status; responses may differ from those elicited by normal developmental stress.
- Severe unexpected stress: This category includes sudden disruption that seriously taxes coping skills; adolescents may fail to resolve and master such stressful events.

Although very little research has been directed to stress response in adolescence, Maddi (1981) speculated on the implications of stress resistance in adolescence from his work on the phenomenon in adulthood. Stressful events are seen as increasing organismic arousal or strain. Strain, continued long enough, can result in various signs of breakdown, or illness of a physical or mental

nature. But several other mediating variables need to be taken into account. Constitutional, personality, and social support factors can influence the coping process and can modulate the magnitude of stress reactions. To Maddi, coping has components of both cognition and action. He differentiates between transformational coping and avoidance coping. Transformational coping decreases the stressfulness of past events through both cognitive appraisal, in which an event appears less stressful when set in perspective, and decisive actions aimed at altering the event to decrease its stressfulness. Coping by avoidance, however, involves pessimistic cognitive appraisal, in which the event is seen as "as bad as it seems," and evasive actions designed to distract or remove the person from interaction with the event. Since it does not change the event, avoidance coping must be continued as protection against the stress. Maddi and his colleagues believe that transformational coping is more advantageous in the long run. They believe that particular characteristics of personality and social supports increase the likelihood of transformational as opposed to avoidance coping and lead to positive mental health practices that can decrease strain reactions. Thus, personality and social supports can maintain health by decreasing both stress and strain. In applying the coping responses to adolescent victims, the pattern of avoidance is well observed and needs serious attention because the majority of assaults go unreported.

Response Patterns to Sexual Assault

To help adolescent victims of sexual assault, one needs to be familiar with stress response patterns. In cases of sudden, unexpected assault that compel their victims to reach out for immediate assistance, the problem is not so much one of case-finding as of emergency support. Because teachers, counselors, and other helping adults are not likely to be first on hand after such rapes occur, at least not on many occasions, the most important thing for them to know is the typical course of a crisis reaction: what is the victim likely to be experiencing in the first few weeks following the assault; 3 months later, 6 months later, and so on; how long can the victim expect to be troubled by rape-related symptoms; and what are the signs of nondisclosed sexual victimization. In contrast to sudden attacks by strangers or near-strangers, date rapes, peer gang rape, acquaintance rapes, and incest present major problems of case-finding. Still, these victims often display telling signs of distress that can be recognized.

Adolescent Reaction to Stranger Rape

Sutherland and Scherl (1970), early workers in rape research, observed a three-phase syndrome of reaction to rape by 13 white

psychiatrically healthy young women, ages 18–24, whom they treated in a public health crisis service. They defined the immediate reaction as an acute phase, characterized by shock and disbelief followed by or alternating with fear and anxiety. The second phase, called pseudo-adjustment, included such coping mechanisms as denial, suppression of affect, and rationalization used to regain equilibrium. The victim resumed normal activities, appeared to be adjusting, and showed little interest in outside help. This reaction is believed to be a healthy response however temporary and superficial it may be. The final phase, integration, often began with the victim feeling depressed and wanting to talk. A specific incident may trigger this phase—pregnancy, a court summons, seeing a man who looks like the assailant, flashbacks. During this phase, the victims must face and resolve feelings about themselves and the assailants. Self-blame and a sense of defilement are common. Anger turned toward the assailant may be felt for the first time or be turned inward, intensifying the early depression. Sutherland and Scherl (1970) observed that fear, anxiety, and depression were within normal limits if reactive, time-limited, and nonpsychotic.

In a hospital-based convenience sample of all persons admitted for rape, Burgess and Holmstrom (1974) analyzed symptoms from 146 persons ages 3 to 73, including 3 males, and described three types of sexual victimization:

- Rape trauma in which the victim was forced into nonconsenting sexual activity
- Accessory-to-sex in which the victim was pressured into sexual activity
- Sex-stress in which the victim initially consented to some type of sexual activity but then experienced great distress.

The analyzed data from 109 child, adolescent, and adult victims subjected to forced sexual penetration revealed similarities in responses that seemed to qualify as a clinical entity, with the nucleus of the anxiety being a subjective state of terror and fear of being harmed and/or killed. This rape trauma triggered intrapsychic disequilibrium with a resultant crisis state for the victim.

The rape trauma syndrome (Burgess and Holmstrom 1974) is divided into two phases that can disrupt the physical, psychological, social, and behavioral aspects of a victim's life. The acute phase can last from days to weeks and is characterized by general stress response symptoms. The common feature of the acute phase is the disorganization of normal, daily activities (e.g., school, socializing) and disruption of essential functions as well as a variety of somatic reactions (skeletal-muscular tension, gastrointestinal irritability, genitourinary disturbance, etc.) and intense emotions

(fear, humiliation, embarrassment, self-blame, vengefulness, etc.). Not all victims experience all symptoms or the same sequence of symptoms, but disorganization seems to be characteristic of this phase.

The second phase of the syndrome is long-term reorganization in which the adolescent victim has to reorder his or her life and integrate the rape event into the life experiences. Reorganization usually begins several weeks following the rape, depending on the characteristics of the attack, the victim's ego strength, his or her resources for social support, and the help and emotional support received. Most victims continue to experience rape-related symptoms, but with a gradual progression of mastery over the fear and anxiety. A number of feelings and behaviors are specifically associated with this phase: intrusive thoughts about the attack, development of phobic behaviors, and increased activity (e.g., attempting to change schools especially if the assailant(s) are also at the school).

Another research team, Bassuk et al. (1975), identified three existential issues specific to the rape crisis response:

- A breakdown of the capacity to deny environmental threats accompanied by powerful feelings of vulnerability and helplessness that disturb the victim's basic sense of safety in the world and so curtail freedom
- A loss of integrity of bodily boundaries following from the rapist's invasion of personal space, which leads in some cases to guilt and sexual inhibition and, in more extreme cases, to psychosis or suicide
- A need to confront existing power relations between men and women with the risk of reawakening hysterical or masochistic feelings.

These existential issues may persist lifelong.

Although the crisis reactions outlined above have been associated mainly with adolescents victimized by strangers, victims of known assailants may experience similar symptoms, prompted by the sense of shock and disbelief they can feel in the aftermath of less violent forms of sexual assault.

Adolescent Reaction to Nonstranger Rape

Incidents included under the rubric nonstranger assault vary from study to study. For instance, one sample may be heavily weighted with incest cases, whereas another may exclude incest entirely; or one sample may comprise incidents perpetrated by assailants who were mere passing acquaintances of their victims, whereas another may involve a high proportion of date rapes. Thus it is no surprise that findings about reactions to nonstranger rape have a high level

of inconsistency. For this reason, any comparisons and observations should be considered suggestive, not definitive.

One-third of the victims in Burgess and Holmstrom's followup to their original study (1979) reported knowing their assailants. The term "known" referred to even the slightest prior relationship, including partner or boyfriend, acquaintance, neighbor, fellow employee, or fellow student. In talking with victims at the time of crisis counseling as well as on followup, it was clear that when the victim knew the assailant issues arose that were not involved in victim-stranger relationships--first, the psychological impact of being raped by someone known and what that means; second, the implications of continuing to deal with one's social group; and third, the legal issue that forces the victim to decide whether to press charges in the face of loyalty ties.

First, the psychological issue. When the rapist is a stranger, victims frequently increase environmental security and psychological defenses against all unknowns. This process is similar to the way many people regularly live their lives; i.e., they act on the assumption that the world is a dangerous place and people need to be tested until proven trustworthy. In contrast, when victims are raped by someone they know, they cannot compartmentalize people into "good" and "possibly dangerous" merely by whether they are strangers. Now they have to start sifting and sorting previously learned attitudes about which people may be potentially dangerous in terms of rape. Victims, therefore, have the psychological task of either learning a new way of predicting dangerous human situations or remaining in a chronic fearful state when relating to people, especially men.

Part of the psychological rape recovery work is to help the victim "explain" what happened. This step is more complicated when the rapist is known and may be quite difficult depending on the degree of relationship with the offender.

The social issue has two components when the victim knows the offender over which s/he has little control. First, the rapist can talk to a group with which the victim has interpersonal ties. Second, the victim is more apt to have interpersonal contact with the assailant and his or her social network.

Because rape is an interpersonal and interactional process involving at least two persons, there is always the possibility that not only the victim but the assailant may inform outsiders and family of the rape. The assailant may tell others for self-serving reasons. In a clinical report of followup counseling of adolescent victims, Felice (1980) identified additional problems faced by the adolescent in coping with the reactions of others in the neighborhood. Victims reported changed response to them by boys and men including leers, lewd jokes, ostracism from the peer group, and minimization of the attack.

The legal issue affects the prosecution of rape cases when the assailant is known. No offenders were convicted in the Burgess and

Holmstrom (1975) sample when rape victims knew their assailants; in contrast, there were seven pleas or convictions for stranger rape cases. While acquaintance rape is more common than stranger rape, it appears to be rarely adjudicated.

Ageton's (1981) findings on reactions to nonstranger assault were similar in kind but different in degree from stranger rapes, moderated perhaps by the low level of violence involved in the incidents she analyzed or by the success that most of her respondents had in resisting their assailants. It is instructive to contrast the reactions of adolescent victims in Ageton's study (92 percent of them victims of nonstranger assault) to the reactions of 59 adolescent and adult victims of mainly stranger assault assessed by Williams and Holmes (1981). The initial emotional response of the nonstranger assault victim was more likely to include guilt, embarrassment, and depression than the response of the stranger-rape victim which included fear, anxiety, apprehension, and confusion. Reactions to nonstranger assault tended to be more variable and less clear cut than reactions to stranger rape, probably because the concept of nonstranger rape itself covers such diverse incidents, from a neighbor's attempted assault on the girl next door to a young man's forced, completed rape of someone he met that evening at a bar.

Adolescent Reaction to Incest

Intrafamily sexual abuse, i.e., incest, and the stress response pattern of the victim is anything but exotic or rare. Both empirical research and victim surveys identify it as an everyday experience for thousands of families in every economic and cultural subgroup in the United States. Recognition, belief, and support for the victims of incest depend on an awareness of new, still controversial data and a willingness to question a number of comforting forms of denial. Sgroi (1975) believes that recognition of incest is entirely dependent on the individual's willingness to entertain the possibility that the condition may exist. She also has analyzed (1982) how clinicians have historically handled incest by denial, emphasizing how those professionals who were in positions to intervene supported the adult, consequently playing into the adult's misuse of power, dominance, and authority, and minimized the credibility of the child. She challenges professionals to develop their ability to understand the reactions of children and adolescents to incest and thus intervene in a positive supportive way instead of avoiding or denying the problem.

There is considerable historical data on the stress reactions of children and adolescents to incest. Goodwin et al. (1979) in reviewing folk beliefs connecting seizures with incest wrote that the second-century Greek physician Galen believed seizures were the result of premature intercourse in childhood (Temkin 1971), and the Navajo Indians have recognized for centuries a tripart syndrome of

incest, seizures, and witchcraft, e.g., when Navajos have seizures it is often assumed they have experienced incest and may be witches (Temkin 1971).

Ferenczi (1949) in a paper published 10 years after it was presented at a Viennese Psychoanalytic Society meeting, documented the outcomes of incest and early childhood sexual trauma as:

- The introjection of the guilt feelings of the adult
- Undeveloped or perverted sexual life
- A traumatic progression of precocious maturity
- The terrorism of suffering

Lystad (1982*b*) in reviewing the professional literature on consequences to victims noted reports of medical hazards, disease, severe anxiety attacks, depression, hostility, anger, self-blame, self-mutilation, and hysterical seizures. Problems in sexual identity and sexual development occurred. A fragmented body image can result, as well as problems in establishing a further relationship with the opposite sex, including promiscuity and an inability to form lasting heterosexual relationships.

Because adolescents are exposed to societal beliefs such as blame-the-victim myths about sexual victimization, they may experience a wider gamut of response from an incestuous relationship than children. Although studies of the impact of incest on children and adolescents are needed, empirical evidence and clinical reports emphasize the traumatic aspects of incest.

Among children and adolescents, gradual social and psychological withdrawal are characteristic reactions to incest and may be particularly pronounced when the victim has been pledged to secrecy and has kept this pledge through an extended period of repeated sexual encounters. The incest secret becomes a symbol of profound difference from other people. Interpersonal relations are impeded by fears of exposing the secret. Social isolation interferes with important development tasks. Specifically, there is inhibited mutual sharing of secrets, fantasies, and significant experiences with friends of the same sex which, in turn, serves a variety of self-validation functions.

Older adolescents frequently react with profound hostility, anxiety, guilt, and depression that may be masked by somatic symptoms and behavioral problems, e.g., learning disabilities, delinquency, promiscuity, drug or alcohol abuse, and, in extreme cases, attempted suicide. Quite often, adolescents will try to remove themselves from incestuous situations by running away. But once on the streets, they become vulnerable to further sexual exploitation in the form of pornography and prostitution. The developmental task of self-identity is markedly impeded.

In summary, clinicians and researchers have identified general patterns of reaction to sexual assault, but there are no absolutes. While a victim of stranger assault, for instance, usually experi-

ences an acute crisis response while a victim of nonstranger rape does not, the reverse may obtain. In sex ring cases where the victimization has been ongoing for months or years, the acute response may occur with the crisis of the disclosure (Burgess 1984).

A framework has been presented in which to view the relationships among some of the developmental tasks of adolescence and the reactions of adolescents to sexual assault—including short- and long-term effects--and to understand the implications of empirical findings presented in later sections.

Family Responses to Adolescent Victimization

The nature of a family's response to the sexual victimization of an adolescent member is mediated by a number of factors, the most important being the method of disclosure of the victimization and the relationship of the offender to the victim.

Disclosure to Parents

The issue of self-disclosure--information about oneself that a person is willing to reveal to others--is an important area of research as well as a clinical issue. Rape disclosure traditionally has not been socially acceptable. It has often been seen as something that lessened the worth of the victim and that was the victim's fault. Self-disclosure is an important clinical issue because one model of intervention encourages victims to talk to members of their social network and to utilize members of the network for support. However, while in some cases members of that network may be supportive of a rape victim, in other cases the members react negatively and cause futher stress for the victim. Symonds (1975) uses the term "second wound" for the trauma unwittingly inflicted by people who deal with the victim after the initial crisis.

Schmidt (1981) reported, from data collected over 3 years with 468 adolescents, that the victims' main concerns were family perceptions of the event and whether they would be believed. Burgess and Holmstrom (1979) analyzed three aspects of disclosure in terms of which parent was told, the ways in which the parent was told, and why the victim told. The most common pattern of self-disclosure was for victims to tell selective family members (42 percent); 33 percent told all family members, and 25 percent told no family members. In this sample, all adolescent victims told their family since the study involved a hospital sample and parental consent was necessary for the adolescent victim to be treated.

In listening to the reasons victims gave for telling selective members of the family, four themes were clear. First, most victims who told wanted to tell family about the rape; they thought it would be helpful to talk about it (39 percent). Second, some victims told out of a sense of expected family behavior (26 percent). Third,

victims sometimes felt pressured—they did not plan to tell family members but a situation evolved that placed them in a difficult position and they told (25 percent). Fourth, in some situations the victims were overwhelmed with feelings and were not able to control their behavior after the rape (10 percent).

Victims had a wide range of feelings about telling family members. Almost half of the victims did not identify any strong positive or negative feelings about telling. Clearly, 25 percent were ambivalent about telling, and the remaining 25 percent reported a wide range of distressful feelings including feeling scared, petrified, emotional, self-conscious, and embarrassed (Burgess and Holmstrom 1979).

The important point to understand about disclosure is that a counseling plan should help the adolescent predict whether the family will be understanding and supportive or blaming. Steps in such an assessment include:

- Gathering information from the victim about the family's prior reaction to stressful news
- Having the victim predict family reaction
- Helping the victim weigh the advantages and disadvantages of disclosure, taking into account the legal implications specific to the State statutes
- Supporting the victim's decision
- Requesting that the victim report on the family reaction so that appropriate support may be provided.

Family Reaction to Stranger Assault on an Adolescent Member

The emotional distress suffered by family members in response to a sexual assault may equal that of the victim. As in rape trauma syndrome for the victim, parents go through an acute effect and a long-term process regardless of the type of assault (Burgess and Holmstrom 1979).

The acute period includes the immediate emotional reaction to the news and need to blame someone. Foley and Davis (1983), in reviewing data on parental response to rape, outlined adaptive stress reactions and maladaptive stress reactions. The adaptive reactions included: care, concern, and support for the victim; feelings of shock, disbelief, dismay, helplessness, and disequilibrium; physical revulsion that may parallel the victim's affective response; anger, rage, and blame directed at the rapist; and viewing rape as a violent act. Actions aimed at adaptation to the event included using distraction tactics to keep victim and themselves

occupied; reaching out to extend family support; cooperating with the victim's medical, counseling, and legal needs; reevaluating previous relationship with the victim; and participating in rape prevention programs.

The maladaptive stress reactions were identified as follows: being primarily concerned with the stigma of rape and how others would think of the family; minimizing the victim's feelings or response; feeling guilty or responsible for not having protected the victim; patronizing or overprotecting the victim; viewing the rape as sexually motivated and blaming the victim; avoiding extended family relationships; lacking empathetic responses with others; failing to seek followup care for the victim; and emotionally isolating the victim.

Family Reaction to Acquaintance Rape

The data on family reactions to acquaintance or nonstranger rape are limited because relatively few families are given the opportunity to react to acquaintance rape; for example, Ageton's study revealed only 22 percent of the victims chose to tell their parents about the incident.

Victims are pressured to keep a rape secret as well as to tell. This observation was made about victims through learning of earlier victimizations that they had not revealed to anyone (Burgess and Holmstrom 1979). Also, attitudes about rape have contributed to keeping victims from reporting a rape. Thus, it is important to learn the reasons victims give for not telling family members. Five themes were identified by Burgess and Holmstrom:

- The victim wished to protect the family from upsetting news. Victims in this category felt they could handle the rape and family members could not.

- Value conflicts with the family led some victims to feel that the family would not understand because of their attitudes about rape, their religious orientation, or their disapproval of the victim's lifestyle, thus blaming the victim for the rape.

- The victims wished to maintain their independence. Adolescents, dealing developmentally with establishing their own identity and eventual independence from the family, felt that telling parents would restrict their independence.

- Some victims felt psychologically distant from their families.

- Some adolescents were geographically distant from family members, usually away from home at school or living in another type of residence from the family.

Although there are obviously many reasons why an adolescent would choose not to tell family members of an acquaintance rape, one important consideration is that in addition to being raped, the victim has the task (if choosing to tell) of dealing with family reactions.

Family Reaction to Incest

A family's reaction to incest is influenced by a variety of factors: the precise relation of the offender to the victim, the nature of the incestuous incident or situation, the manner of discovery or disclosure by family members other than those involved, the manner of disclosure to individuals or agencies outside the family, and the response of these outside individuals and agencies. In effect, a family's reaction to incest is a uniquely evolving series of responses associated first with discovery by the family and then with disclosure to outsiders.

When the offender is a family member, families are caught between two conflicting expectations: they should be loyal to the adolescent and treat the offender as they would treat any assailant--thinking of their duty as citizens to bring such an offender before the law. But, they should be loyal to the offender and make an exception for him because he is a family member and let their duty to him as a particular individual prevail. Clearly they cannot honor both expectations, and the choice may be difficult.

Psychologically, having to side with one of two family members is experienced as a sense of divided loyalty. The decision by the adolescent to disclose a family member assault is not made easily and more often than not the assault is quite prolonged; that is, the sexual abuse could have been initiated when the adolescent was a child. This fact was confirmed in one study (Burgess et al. 1977) when over half (28 of 44 victims) reported that the sexual assault by the family member occurred more than once before it was brought to someone's attention. Delay by the family in deciding to tell an outside group is equally complicated.

Researchers have looked at those adult family members not directly involved in the incest who know about it and are able to do something about it. These persons who fail to intervene are called colluders (Lystad 1982*b*). According to Lystad, research on colluders has concentrated on father/daughter incest. Browning and Boatman's (1977) clinical study of 14 incest cases showed the mother to be chronically depressed. Herman and Hirschman's (1977) clinical study of 40 cases showed the mothers to be chronically ill or disabled and often absent from the home. The reasons cited for mothers not functioning in their maternal roles and providing protection to their daughters included untreated depression, alcoholism, psychosis, or repeated involuntary childbearing.

Sgroi (1982) outlined the characteristics and treatment needs of incest families:

- *Abuse of power.* Aggressive rather than benevolent use of power by the strong adult against the weak child or adolescent becomes the family pattern of interaction.

- *Fear of authority.* There is a guilty flavor to the fear of outside authority experienced by members of incest families, due perhaps to anticipation of discovery and fear of consequences.

- *Isolation.* The adult discourages the adolescent from establishing alliances with outsiders which, in turn, increases the power the adult has over the child.

- *Denial.* An enormous amount of energy is exerted by the incest family on denial. This denial runs parallel with the social isolation of the family.

- *Poor communication patterns.* The family's isolation decreases opportunities to communicate with others, and poor communication between family members is the rule rather than the exception.

- *Lack of empathy.* The perpetrator is unable to empathize with the adolescent, is totally unresponsive to the needs of the child. This insensitivity to others is rooted in denial and in the inability to communicate.

- *Inadequate controls and limit setting.* The adults in incestuous relationships show poor impulse control and the inability to set realistic limits upon themselves. Immediate gratification of their own needs prevail.

- *Blurred boundaries.* There is a blurring of role boundaries and role confusion in parental incest families.

- *Extreme emotional deprivation and neediness.* The incest parents' lifelong pattern of failure to satisfy their own needs is taught to their own children.

- *Magical expectations.* The belief of those parents who are in incest families in a magical solution for their family problems far exceeds their capacity to view the incest as a problem to be terminated and resolved.

Chapter 3

Meeting the Needs of Victims and Offenders

Disclosure Patterns in Sexual Assault and Ways to Identify Suspected Cases

Because so many cases of adolescent sexual assault are not disclosed by the victim, adults need to be alert to the observable symptoms and behaviors of sexual victimization. The following sections describe three responses to victimization: (1) silent reaction to rape, (2) continuing sexual abuse, and (3) chronic unresolved sexual trauma.

Silent Reaction to Rape

The following symptoms may be observed in the adolescent who has not reported a rape to anyone, who has not dealt with feelings and reactions to the incident, and who, because of this silence, has further burdened herself or himself psychologically (Burgess and Holmstrom 1974).

- Increasing signs of anxiety as an interview progresses, such as long periods of silence, blocking on associations, minor stuttering, and physical distress
- Marked behavioral changes such as irritability, avoidance of interaction with men, changes in school behavior
- Sudden onset of phobic reactions and fear of being alone, going outside, or being inside
- Sudden loss of self-confidence and self-esteem, self-blame attitude, paranoid feelings, dreams of violence and nightmares.

Continuing Sexual Abuse

Adolescents who have been pressured into sexual activity with an adult find it very difficult to end the abuse. Sgroi (1982) noted

several behavioral indicators that may directly or indirectly suggest that a young person is the subject of ongoing sexual abuse:

- Overly compliant behavior
- Acting-out, aggressive behavior
- Pseudomature behavior
- Hints about sexual activity
- Persistent and inappropriate sexual play with peers or toys or with themselves, or sexually aggressive behavior with others
- Detailed and age-inappropriate understanding of sexual behavior
- Arriving at school early and leaving late with few, if any, absences
- Poor peer relationships or inability to make friends
- Lack of trust, particularly with significant others
- Nonparticipation in school and social activities
- Inability to concentrate in school
- Sudden drop in school performance
- Extraordinary fear of males or seductive behavior with males
- Running away from home
- Sleep disturbance; somatic complaints such as headaches, stomach aches, urinary tract problems
- Regressive behavior
- Clinical depression
- Suicidal feelings

Chronic, Unresolved Sexual Trauma

Both the silent reaction to rape and continuing sexual abuse situations have the potential to develop into unresolved sexual trauma. An unresolved issue is a psychological term referring to a

significant event in a person's life which remains unsettled at an emotional level. The impact of feelings attached to the event has the potential to create disturbing reactions and behaviors. When a child has been pressured into continuing undetected sexual activity with an adult, as through incest or sex rings (Burgess et al. 1981), the child may be programmed to provide sexual services in exchange for a variety of psychological, social, monetary, and other rewards. This learned behavior becomes repetitive and may continue into adolescence, when the youth is at risk for entering prostitution. A study of sex crimes against children (Burgess 1984) illustrates how youth prostitution rings are organized and operate and include pornography.

It is essential for adults to understand the dynamics of unresolved sexual victimization to sexually delinquent behavior. Such behavior, e.g., sexual demeanor, dress, and language; sexually explicit behavior including indiscriminate sexual partner selection; and promiscuity, may be symptoms of chronic unresolved sexual victimization. Thus, case-finding for early continuing sexual abuse of adolescents is crucial for prevention of youth prostitution and pornography.

Victim Needs

The needs of sexual assault victims vary widely. They depend, for instance, on the nature of the incident, when it took place, the physical and emotional injuries the victim sustained, the actions being considered as a result, the resources available for informal support, and the anticipated reactions of people in the informal support network.

The need for emotional support is universal among victims and may be sought from a variety of sources, e.g., family, peers, teachers. Protection from the abuser may be needed as well, particularly in cases of incest. Almost by definition, victims who seek assistance need help in solving rape-related problems. For the adolescent victim of sexual assault, dealing with parents usually is a most pressing problem and, in fact, becomes crucial if the victim has immediate medical needs that cannot be met without parental consent. For the victim of incest, dealing with the family's response to disclosure is a most distressing problem and one that may require timely intervention by a multidisciplinary team of medical, legal, social service, and mental health professionals. Information needs for the victim include law enforcement practices, medical services, social services, criminal justice procedures, and miscellaneous forms of assistance. Referral and advocacy needs follow from the victim's determined plans for redressing and treating his or her physical and psychological injuries. All of the above needs can be wholly or partially addressed by a well-informed, concerned adult.

Some victim needs require the attention of professional providers. Primary health care, for instance, is essential when victims have sustained injury or been exposed to the risk of pregnancy or venereal disease. If there are plans to pursue the case legally, the health care procedure should include physical evidence collection. The extent of psychological services needed depends on the victim's responsiveness to intervention. There is general consensus that all victims of rape can profit from immediate crisis intervention counseling. Hospitals may have nurses providing such services or special teams may be established on an on-call basis. Rape crisis centers often link in to the hospital team and provide such service. Legal intervention, associated with the pursuit of the offender and/or the protection of the victim, should be discussed with persons knowledgeable in the law and familiar with the case. Social services look to the basic human needs of the victim in the aftermath of an assault, and they are equipped to suggest resources appropriate to the nature of the support predicted in the home. Finally, education is a universal need among adolescent victims.

The Helping Process

This section focuses on the specific aspects of providing help to the sexually victimized adolescent who has disclosed the assault. The following material describes general steps in the helping process and listening and communication techniques useful at various points in the process.

General steps in the helping process. A basic principle in working with sexually victimized adolescents is that they are essentially normal adolescents who have experienced a major stressful event. Most of the problems that appear are likely, therefore, to be directly related to the rape.

The process recommeded for helping adolescents often starts with crisis intervention, which can be provided by trained and supervised paraprofessionals and volunteers (Farberow and Gordon 1981). The primary goal in crisis intervention is to identify, respond to, and relieve the stresses developed as a result of the crisis (rape) and then to reestablish normal functioning as quickly as possible. As previously discussed, sometimes the reaction is mild; other times it is severe. The workers must be trained to recognize when the condition is mild and can be handled by the families (with guidance) and when it is severe and needs professional help.

The general steps in the helping process are described by Farberow and Gordon (1981) as follows:

1. Establish rapport.

    a. Let the adolescent know you are interested and want to help.

b. Check with the adolescents to make sure they understand what you are saying and that you understand them.

c. Have genuine respect and regard for the adolescents.

d. Communicate trust and promise only what you can do.

e. Communicate acceptance of the adolescents.

f. Communicate to the adolescents that you are an informed authority willing to help with the crisis.

2. Identify, define, and focus on the problem. Like adults, adolescents going through a crisis may seem confused and chaotic in their thinking. It is helpful for the adolescent to identify a specific problem, define it, and focus on it first. If possible, the problem should be quickly resolved so that the adolescent can experience a sense of success and control. Evaluating the seriousness of the problem should determine the adolescent's and his or her family's capacity for dealing with it.

3. Understand feelings. Empathy is the ability to see and feel as others do. Being empathetic with adolescents requires patience, for they are frequently unable to express their fears, and the adults need to appreciate the kind and intensity of their feelings. For example, adults may be required to listen to an account of the rape many times while the adolescent works through the crisis by talking it out.

4. Listen carefully. Frequently, the adolescent's experiences of adults listening to them are unsatisfactory. In working with adolescents, effort should be made to respond to them and to comment frequently. Interrupting should be avoided for it tends to happen often and the adolescent may be particularly sensitive to being interrupted by adults.

5. Communicate clearly. It is important to communicate in simple language the adolescents understand so that they are included in the helping process. The presence of the family may be useful in the interview, but the adolescents should be asked first if they wish a family member present. A major issue in rape is lack of control and thus all helping efforts should be geared toward providing the adolescents opportunities to regain control in their lives.

Problem-solving procedures. Standard problem-solving procedures provide the underlying structure for an effective response to victims of sexual assault. But before any problem-solving trans-

actions can take place, victims need to be assured that the listener will be nonjudgmental and accepting. Thus, in cases of sexual victimization, the standard approach to problem solving must incorporate measures for making victims feel comfortable.

The following guidelines for assisting victims do not constitute a strict protocol. Instead, they suggest the ground that should be covered, listening and communicating techniques, and a logical way of proceeding. Not all steps need to be taken with all victims, however, and not necessarily in the order given.

1. Provide the victim with emotional support and establish an interpersonal climate conducive to problem solving. Emotional support is often a compelling need, an undeniable prerequisite to any problem-solving activities. Thus, the following measures of support and assurance may be essential in many cases.

   a. Respond to the victim's immediate situation.

      - Comfort and calm the victim, if appropriate.

      - Tend to the immediate physical needs, if any.

   b. Allow the victim to feel comfortable about approaching you.

      - Find a quiet place to encourage the victim to talk.

      - If the victim is talking freely, be an attentive, empathetic, and nonjudgmental listener. Use body language to express acceptance; maintain a relaxed open posture.

      - If the victim is having trouble expressing himself or herself, allow time; when the moment seems right, use simple, quiet interjections. Use positive silence and body language to demonstrate attentiveness and interest and to encourage conversation.

   c. Elicit the victim's feelings and concerns.

      - Once the victim has started talking coherently, encourage further expression of feelings and concerns as precisely as possible in order to highlight important issues.

      - Let the victim prioritize the issues.

      - Support expression of feelings and concerns regarding the assault.

2. Undertake problem-solving tasks. Once victims have expressed their feelings and concerns coherently, it is possible to begin problem solving. A certain tension may arise with the shift in roles from comforter to problem solver. Rapport may be broken at this point if the victim does not feel assured of the intervenor's concern with his or her needs. Progress in problem solving often is interrupted by bursts of emotion that require renewed comforting efforts.

As previously described, open-ended expression, silence, encouraging responses, and attending behaviors by the intervenor are employed mainly to make the victim feel comfortable and to encourage the expression of feelings and emotions. Reflecting responses and paraphrasing are used to encourage further expression of thoughts and concerns and to assure that the intervenor has interpreted these correctly.

Probing, refocusing, clarifying, and pointing out contradictions are all techniques for assuring accurate and complete understanding of the victim's problems and for concentrating attention on these problems. Approving, informing, and advising techniques are used when victim and intervenor begin to explore solutions and to develop strategies for implementing these solutions. Informing and advising are also major ingredients of anticipatory guidance.

At some point in the helping process, the intervenor should try to reach the following goals:

1. Clarify and prioritize the victim's problems.

   - If appropriate, identify any significant issues not apprehended or raised by the victim (e.g., the possibility of pregnancy or venereal disease).

   - Help the victim organize his or her concerns in order of importance.

2. Develop alternative solutions for identified problems.

   - Explore alternative solutions for each problem under consideration.

   - Consider the feasibility of each alternative—the resource needed to implement it, the likely outcome, the undesirable consequences that may result.

3. Evaluate and select alternative solutions.

   - Consider the costs and benefits of alternative solutions.

   - Select the most promising alternative.

Develop strategies for implementing selected solutions. During problem-solving encounters with sexually victimized adolescents, the issue of parental involvement arises again and again, and becomes, at this stage, paramount. As mentioned, in cases requiring the intervention of professionals who need parental consent before treating minors, parents must be involved. And in all cases, of course, understanding and cooperation from parents is a most desired outcome. But when incest is the issue or when the young person anticipates an explosive reaction from parents, the original intervenor may need assistance from someone who already possesses or could easily gain the parents' trust; e.g., a family doctor, clergyman, skilled social worker, or family counselor or school nurse.

Once the question of family participation has been confronted, the logical next steps are to:

1. Identify resources needed to implement selected solutions.

2. Identify precise agencies and individuals to be involved, e.g., medical facilities, mental health center, social service agency, family counselor.

3. Identify precise steps to be taken.

Implement selected solutions. At this point, the intervenor begins to connect the victim to other sources of assistance; specifically the intervenor may:

1. Refer and educate the victim to available sources of medical help. Primary medical care usually includes general physical examination, pelvic examination, oral and anal cultures, evidence collection, baseline pregnancy and venereal disease tests, other laboratory tests as needed, prophylactic VD treatment, and anti-pregnancy information. Followup medical care includes VD tests and pregnancy tests.

2. Refer and educate the victim to available sources of psychological counseling. Victim counseling usually includes immediate crisis intervention, weekly followup visits, longer term counseling if indicated, referral to self-help groups, home counseling, and counseling for family and friends.

3. Refer and educate the victim to available social services. The social services generally available include emergency shelter, foster care and group home placement.

4. Refer and educate the victim to available legal services. The legal intervention generally includes evidence collection, victim compensation, third-party reporting, and protective custody.

5. If necessary, accompany the victim to these appointments.

6. Involve the victim's family, if necessary and appropriate.

Provide the victim with anticipatory guidance. It is unlikely that a victim's problems can be eliminated in a single encounter; accordingly, anticipatory guidance is almost always required, particularly for victims in crisis or victims of incest. One or more of the following steps probably will be necessary in any given case.

1. Suggest possible future reactions; review the elements of the rape trauma syndrome with victims explaining that they may or may not suffer from some of these symptoms and that they should seek immediate assistance if the symptoms themselves become overly distressing.

2. Suggest possible future reactions of her or his parents and siblings; victims should understand that parents and siblings can experience a crisis response very similar to their own and that they too may require counseling and support. Incest victims should be encouraged to look beyond their family's possible anger to the relief that eventually may follow from disclosure; they should be assured of the rightness of their revelation and the availability of professional help to deal with family issues.

3. The original intervenors should consider themselves the primary providers and, unless otherwise indicated, should check back with the victims to assure that they are continuing to resolve the crisis. Maintaining contact with the victims is the best way to monitor their progress and to advise participating professionals or the victim's parents of the need for additional intervention.

Offender Needs

A discussion of sexual victimization of adolescents would be incomplete without information regarding the offender. This section looks at the offender and the motivation underlying the behavior.

The Stranger Rapist

Only a minority of rapes end in conviction of an offender. Rabkin (1979), using FBI figures, noted for every 100 reported rape cases, 51 arrests were made; 16 of those arrested were convicted of forcible rape and another 4 were convicted of a lesser charge. It is this group of offenders, usually strangers to their victims, who tend

to be sentenced to prison and thus become available for study.

Reviewing convicted offender studies, the majority of offenders charged with rape are between the ages of 16 and 25. The highest frequencies include 16–20 year olds, while 21–25 year olds generate the next highest rate. Gebhard et al. (1968) found the majority of rapists whose victims were more than 12 years old were themselves between 16 and 30. Amir, analyzing 1,300 police reports of offenders charged between 1958 and 1960 found 40 percent between ages 15–19 and another 26 percent aged 20–24. FBI Uniform Crime Reports (1980) showed 57 percent of the forcible rape arrests in 1979 were males under the age of 25, with 30 percent of arrests in the 18–22 age group. Fifty percent of the persons arrested were white, 48 percent were black, and all other races comprised the remainder. Thus, it appears the stranger rapist is often a teenager or young adult male.

To date, studies of sexual assault have not collected or analyzed data at the level of detail necessary to generate specific findings about stranger rape among adolescents. Stranger rapes, in general, involve children, adolescents or adults, and tend to be more sudden, blitz types than nonstranger assaults.

Acquaintance Rapists

Empirical studies are suggesting that violence and sex in our society are intertwined in complex ways. Rape may be on a continuum with what many people presently regard as normal heterosexual relationships. Groth (1979) argues strongly that attention should be paid to the adolescent male who commits sexual assault, citing the reluctance of courts and other agencies to view juvenile sex offenses as significant and serious. In his study of adolescent sex offenders, Groth profiled the male as in his mid-teens, white, of average intelligence, carrying out the assault alone, and targeting a victim about a year younger than he. It was equally likely that victim and offender knew each other at least casually, and the offense was twice as likely to occur indoors as outside. In 75 percent of the offenders studied, there had been a previous offense which was disposed of without any type of referral or commitment.

Incest Offenders

Incestuous offenses are not limited to sexual activity between a biological father and daughter, but encompass any sexual relationship in which the adult occupies an authority role in relation to the adolescent, such as adoptive, step, or common-law parent. The concern is more with age-power relationships, the betrayal of a trusted caretaker, and the young person's sense that he or she has been sexually violated and less with the technicalities of penetration or genital touching.

Both the clinical literature and adult incest victim reports de-

scribe the family constellation as appearing conventional to the outside world. Herman (1985) argues that the incestuous family structure represents a pathological exaggeration of generally accepted patriarchal norms. And because of the socially accepted paternal dominance of our society, the abuse of paternal dominance often goes unrecognized. Incestuous fathers may be respected in their communities and seen as providing well for their families, with the wives often completely dependent upon them for economic survival. Careful interviewing of these families often reveals that incestuous fathers enforce their dominance through violence within the family. And, as Herman observed, because incestuous fathers are often so exquisitely sensitive to the realities of power, they rarely attempt to intimidate anyone who has equal or greater social status, e.g., a professional; they try to gain sympathy and seek to minimize, deny, or rationalize their abusive behavior. Through this subtle manipulation, naive clinicians may incorrectly interpret the father as a relatively powerless figure in a mother-dominated system.

Motivation of the Offender

Why do rapists rape? Contemporary views of rapists, starting in the 1970s, include the feminist perspective that rape serves the function of social control (Brownmiller 1975) and keeps women in their place (Weiss and Borges 1973). From the sociological perspective rape is behavior learned through interactions with others (Scully and Marolla 1982). Clinically, rapists have been classified by descriptive categories (Rada 1978) and by psychological motivation (Cohen et al. 1971; Groth 1979). The concept of rape as a pseudosexual act and as an act of violence and power rather than primarily a sexual act has been of pragmatic assistance in assessing impact on victims. On the basis of clinical data on 133 convicted rapists and 92 adult victims, Groth, Burgess and Holmstrom (1977) viewed rape as complex and multidetermined and addressing issues of hostility (anger) and control (power) more than passion (sexuality).

In *anger* rape, sexuality is used to express and discharge pent-up anger and rage. The assault is characterized by physical brutality. Far more force is used in the commission of the offense than would be necessary if the intent were simply to overpower the victim and achieve sexual penetration. Sex becomes the weapon by which the offender can degrade his victim. It is the means of retaliation for what the offender perceives or has experienced to be wrongs suffered at the hands of important persons in his life and he is seeking to hurt, punish, degrade, and humiliate his victim.

In *power* rape, the dominant factor is control over another person. Incest cases probably fall into this category. Sexuality becomes the means of compensating for underlying feelings of

inadequacy and serves to express mastery, strength, authority, and identity. There is a desperate need on the part of the offender to reassure himself about his adequacy and competency as a man. Rape allows him to feel strong, powerful, and in control of someone else. He hopes his victim will welcome and be impressed with his sexual prowess so he may feel reassured that he is a desirable person. Through rape he hopes to deny any deep-seated feelings of inadequacy, worthlessness, and vulnerability and to shut out disturbing doubts about his masculinity.

The dynamics of pressured sexuality are often used between adults and adolescents. Dominance by authority is used to ensure sexual control over a person. This offense is characterized by a relative lack of physical force in the commission of the offense; in fact, the offender generally behaves in counter-aggressive ways. His typical behavior is either one of enticement in which he attempts to sexually engage the young person through persuasion or cajolement, or one of entrapment in which he takes advantage of having put the adolescent in a situation where the victim feels indebted or obligated in some way to the offender. This offender tries to persuade his victim to cooperate or consent to the sexual relationship, often by bribing or rewarding the adolescent with attention, affection, approval, money, gifts, treats and good times. In such situations, sexuality appears to be in the service of dependency needs for physical contact and affection. In all cases, the offender attempts to pledge the victim to silence.

Community Referral

People who work with adolescents often find themselves serving as referral agents for victimized and troubled young people. Especially in cases of incest, the school nurse, counselor, teacher, and social worker may form a multidisciplinary team for case finding, emergency intervention, and preliminary evaluation of the victim's need for more specialized treatment and referral. To serve effectively in this capacity, it is important to have full knowledge of the local agencies available to meet the victim's and his or her family's immediate and long-term needs. Specifically, one should be prepared to provide information on the nature and availability of appropriate medical services; the nature and extent of local police investigations; the kind of counseling, advocacy, and social services available for victims and their families; and the court procedures involved in various types of sexual assault cases.

Developing this level of knowledge requires a thorough investigation of local resources. As a minimum, the following four steps are involved (Hummer 1982):

- Identify the agencies in the community that take some responsibility for meeting the needs of sexual assault victims.

- Divide identified agencies into two groups, primary agencies and secondary agencies.

  - Primary agencies are directly concerned with the immediate needs of the victim; e.g., (1) emotional support through community mental health centers, rape crisis centers, crisis hotlines; (2) medical treatment through hospital-based sexual assault units, emergency rooms, clinics; (3) criminal investigation by law enforcement through police or county sheriff; (4) legal assistance through prosecutor's offices and probation departments; (5) social services through Child Protective divisions, Commissions for Women, Family and Child Services, Parents United (incest), Planned Parenthood, religious organizations, YWCA.

  - Secondary agencies address the less immediate needs of sexual assault victims, e.g., long-term therapy, medical followup, employment assistance, assistance with medical costs as through victim compensation funds.

In effect, primary agencies are those a victim needs during the first 48 hours or so after an assault and secondary agencies are those a victim may need at some later time. (Note: A single agency may function in both primary and secondary capacities with regard to sexual assault victims.)

- Develop vital information on each primary and secondary agency BUT DO NOT REINVENT THE WHEEL. Call local libraries, human resource bureaus, and a number of primary agencies to determine whether such information has been collected and compiled recently. If no such information is available, proceed with a telephone survey, mail survey, and search of local documents.

- Compile information on the local victim assistance network in a convenient format. The standard information that is helpful to have available for victims includes the following:

  - Name and location of agency

  - Emergency phone number; business phone number

  - Name(s) and telephone number(s) of contact person(s) for sexual assault cases; title(s), and number(s) of particular staff members handling sexual assault cases, if different

  - Hours of operation

- Client access (walk-in? appointment only? referral only?); client restriction (age? residence? income? number of appointments? other?)

- Services provided/procedures followed; languages in which services provided

Chapter 4

Prevention Strategies

The analyses by social scientists, behavioral scientists, clinicians, and others suggest that rape, sexual assault, and incest are fostered by certain ideological beliefs and by certain social structures (Holmstrom & Burgess 1983). This broad interpretation looks at the social–cultural parameters that promote the development of psychological/behavioral motivations to rape, e.g., those theories that suggest rape is learned behavior.

There are both optimistic and pessimistic implications of such an interpretation. On the encouraging side, the high rates of rape are not inevitable; a society could be rape free (Sanday 1981) or at least have very low rates of rape. The less encouraging implication is that to eliminate rape, sexual assault, and incest in our society would require radical changes in ideology and social structure, a truly awesome task (Holmstrom and Burgess 1983). Thus, it seems more fruitful to focus attention for the present on more immediate interventions and strategies in terms of community, family, and individuals.

Strategies to prevent sexual assault seem to vary along two dimensions. One dimension is whether the strategy aims at the individual or family or at the institution or community level. Granted that all strategies ultimately aim to change people, some strategies are more geared toward dealing with individuals and others are aimed at altering and/or influencing institutional structures (such as a school curriculum). A second dimension is whether the primary goal is to effect change prior to a sexual assault or after the fact to prevent repetition of the sexually aggressive act (Holmstrom and Burgess 1983).

For the Community

A wide range of changes at the community level could help to prevent rape, sexual assault, and incest. Prevention programs directed to the community can help citizens to understand the problem and assume responsibility for responding to it (Lystad 1982*b*). For example, the Montgomery County Sexual Offenses Committee (1975) recommended that a community education program include:

sexual offense workshops for teachers, block parent programs, mass media educational programs dealing with sexual assault in and out of the family, and education on child abuse laws and citizen responsibility.

The schools are crucial in promoting changes in the socialization of children. The findings of Goodchilds and colleagues (1979) on adolescent sexual socialization show how *early* ideas about male–female relationships are formulated. School curriculums can help children understand their own bodies so that they will be better able to protect themselves from abuse; such a program is outlined by Montgomery County (1975) in Maryland for children in kindergarten through twelfth grade. There are also incest prevention programs for the schools that often contain components for parents and children. Gieser (1979) suggested including a discussion of self-respect and personal rights, urging children to report any sexual advances to a trusted adult to minimize the trauma of the reporting process. Luther and Price (1980) view the health educator in the school system as important in identifying the sexually abused child and as a resource person for helping the child.

The following are general suggestions for how communities might organize and develop strategies for preventing sexual aggression.

Stranger Rape

In terms of stranger rape, the following strategies are suggested:

- Public information and education to change rape-supportive attitudes
- Legislative reform of rape laws and changes in institutional policies
- Community pressure to stop rape
- Increased police visibility

Nonstranger Rape

Strategies suggested to prevent nonstranger rapes include the following:

- Changed media portrayals of sex roles
- Public information and education about acquaintance rape
- Educational curriculums for schools on human sexuality and child sexual abuse

- Promotion of "Rape Prevention Week" campaigns

Incest

Suggestions for designing community strategies to prevent incest include:

- Public forums and workshops on conditions predisposing to incest
- Evaluation of legal reforms regarding court appearances for young victims
- Implementation of uniform reporting codes
- Networking with institutions to develop intervention programs to identify and treat families in stress
- Integrating isolated families into the larger community
- Developing neighborhood programs to stress awareness and mutual support

For the Family

Parent-adolescent interaction is a key factor in any prevention program involving families. The prevention of sexual assault, including stranger, acquaintance, and/or incest, means dealing with sensitive aspects of human sexuality. There often is a common reluctance to discuss issues of sexuality because of anxiety and embarrassment. However, several researchers strongly support such interactions. As Finkelhor (1979) argues, to give priority to the issue of sexual victimization means acting on it directly, teaching children who may be potential victims how to avoid it, and re-emphasizing for the benefit of potential abusers that such behavior is damaging and wrong to the child or adolescent.

Swift (1977) found in her research that offenders tended to be both sexually ignorant and sexually immature. She suggested one prevention strategy: educate parents about age-related, sexually appropriate behavior through the life cycle and about the serious, long-range consequences of sexual abuse of young people.

Finkelhor (1979) states that families in which sexual abuse occurs are often socially isolated. Thus, networking of services may be an important intervention strategy to assist families in positive interactions and to assist them in handling sexual problems once they first manifest themselves.

Lystad (1975) writes that because of a cultural background of male dominance and violence toward women, some men feel that

physical and sexual abuse is all right since they are male heads of households and some women and girls feel powerless against such violence. Therefore, one prevention strategy is to teach parents the need to socialize female children so that they develop positive self-images and expectations for themselves, a sense of bodily privacy, and the ability to say no to intrusions. Parents should also be made aware of the need to socialize male children so that they develop positive self-images and expectations for themselves, a sense of bodily privacy, and respect for the personal space of others.

Lystad also stated that a serious social consequence of child sexual abuse is transmission of such violence from generation to generation. Those parents who interact with a high degree of violence transmit this method of interaction to their children. A prevention strategy is to make educators aware of the rights and responsibilities of both male and female children in their physical interactions in school and on the playground and of teachers' responsibility for providing appropriate role models. In addition, educating the community at large about the severity of the problem and the need for both intervention and prevention services that are accessible to all kinds of families, especially those already at risk, might prove effective.

The following prevention strategies for families are suggested.

Stranger Rape

Parents will often discuss with their adolescents sexual assaults in which the offender is a stranger. Children may have been taught that there are strange men who offer children candy and such persons must be avoided. Specific prevention strategies include:

- Instruction in elements of vulnerability
- Increased environmental safety measures--outside and inside home and car, e.g., deadbolt locks
- Action training to reduce isolation among adolescents in the community
- Training in self-defense

Nonstranger Rape

Traditionally it has been difficult to develop programs to prevent date and acquaintance rape. Unlike stranger rape, acquaintance rape often occurs when the persons involved have been socially together and events turn to a pressured or forced sexual conclusion. Some of the specific strategies to be considered include:

- Debunking myths about male and female sexuality that support the use of aggression in a date situation and fail to emphasize the concept of mutual consent
- Distinguishing sexual aggression from adolescent sexual experimentation
- Educating adolescents in self-determining sexuality
- Training in sexually responsible and appropriate dating behavior

Incest

Several prevention strategies have been suggested for helping families deal with the issue of incest.

- Suggesting techniques for coping with the anxieties and stresses in the home and in the work force
- Teaching effective methods of handling sexual feelings for family members
- Exposing the family to health perspectives on adolescent/adult relationships
- Establishing appropriate pursuits to reinforce personal self-worth
- Educating on the deleterious effects of incest on children

For the Individual

In the early 1970s, Peters (1973) described child sexual assault as a "psychological time bomb" which he predicted to be totally destructive to later adult adjustment even when the child showed no immediate signs of emotional trauma. While it is clear that sexual abuse of young persons is not the sole cause of identity crises or emotional disorders, recent empirical clinical studies inspire some radical claims. Crisis counseling of incest trauma has provided dramatic remissions of major mental illness and behavior disorders in selected cases (Summit 1981). Thus, the hypothesis of a single trauma etiology in these patients raises promise for primary prevention of mental illness from childhood sexual abuse if cases are detected and resolved early. As noted in other forms of child maltreatment, there is the generational bonus of prevention if the victim can be identified and reparented. Clinical reports are emphasizing that today's victim may be tomorrow's offender and that boy victims tend to repeat their experiences on younger boys

and/or girls (Groth 1982). Thus, it becomes especially important to have prevention programs for both the victim and the offender.

Stranger Rape

The following strategies are suggested for dealing with the individual adolescent victim as well as the offender.

- Teach individual to avoid sexual assault before it happens
- Re-educate adolescents in the socialization process
- Train individuals in principles of fight vs. flight when confronted with a dangerous sexually aggressive situation
- Promote everyday strategies for prevention of attack
- Continue to improve the processing of rape cases to help in obtaining convictions and encouraging reporting of rape
- Rehabilitate offenders after conviction to prevent future rapes

Nonstranger Rape

The following suggestions are offered in terms of nonstranger rape and date and/or acquaintance rape.

- Promote understanding of acquaintance rape
- Decrease psychological vulnerability to threats of sexual aggression
- Create awareness of prerape cues and signals in social contexts
- Teach adolescent males nonsexist attitudes
- Provide acceptable models of sexual expression
- Encourage healthy, direct communication between adolescents
- Promote positive self-images of adolescent females

Incest

The following suggestions are provided for dealing with the individual adolescent and the problem of incest.

- Instill the right to exercise control over one's body; the right to say no in matters of sexuality

- Ensure support for resisting victimization and reporting it to a trusted adult
- Teach appropriate adult/adolescent physical interaction
- Teach them to differentiate between the authority of adults and their own rights in matters of sexuality

In conclusion, no single change will eliminate rape, sexual assault, or incest or even dramatically reduce their occurrence. Rather, multiple strategies need to be employed to have any impact on the problem of the sexual victimization of the adolescent.

Summary

The implications are clear. Our culture has a large and highly vulnerable population of young people who have experienced or are at risk for experiencing sexual assault of the types discussed in this manual. Because adolescents are least likely to report sexual victimization, they are least likely to seek treatment. As a result, their assault-related traumas may go unresolved and so affect them throughout their lives. Adults whose work brings them into contact with young people can play an essential role in preventing or ameliorating sexual trauma by, first, being aware of the magnitude of the problem; second, by being alert to the signs of distress and then suspecting victimization; and third, by making the appropriate referral for intervention when the situation has been confirmed.

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